

**Investigation into the circumstances surrounding the
death of a man in November 2010 at hospital,
whilst in the custody of HMP Wakefield**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Wakefield. He died at hospital in November 2010, having been admitted nearly two weeks earlier. He was an older prisoner, aged over 80. The cause of death was found to be bronchial pneumonia. I offer my sincere sympathy and condolences to his family and all who have been affected by his loss.

The investigation was carried out by my colleague. A review of the man's clinical care in prison was carried out by a clinical reviewer, on behalf of the local Primary Care Trust. I am most grateful to her for her assistance.

I would also like to thank the Governor and staff of Wakefield for their co-operation during the course of the investigation. My particular thanks go to the Head of Litigation and his colleague for their work in liaising with the investigator.

Although he was an older and frail prisoner, the man had settled well at Wakefield. The medical care he received is judged by the clinical reviewer to be of an appropriate standard. I make two recommendations in this report, the most significant of which refers to the risk assessment process when a prisoner is taken to hospital.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

May 2011

CONTENTS

Summary

The investigation process

HMP Wakefield

Key events

Issues

Conclusion

Recommendations

SUMMARY

The man arrived at HMP Wakefield on 23 June 2003, having been sentenced to 12 years imprisonment. He was 75 years old at the time and had a number of medical conditions, including high blood pressure and diabetes. He settled in well at Wakefield, and was described as a quiet man who got on well with staff and other prisoners.

In late 2007, he was diagnosed with intermittent claudication (cramping pain in the legs caused by a lack of oxygen due to poor blood supply). His mobility began to deteriorate in 2008, particularly over longer distances, and he was referred to the prison's disability liaison officer. Arrangements were made to help him collect his meals and his cell was cleaned by other prisoners.

His mobility deteriorated further in 2009. He was provided with a wheelchair to cover longer distances around the prison. He was provisionally diagnosed with chronic obstructive pulmonary disease (COPD, the obstruction of airflow in the lungs due to chronic bronchitis or emphysema) at a visiting consultant's respiratory clinic, but the test requested by the consultant did not go ahead. I understand that a prison nurse has now been trained to undertake these respiratory tests.

After showing signs of confusion and left sided weakness in September 2010, he was admitted to the prison's healthcare centre for observation and assessment. He returned to his wing later in the month. An ambulance was called for him on 4 November. He appeared confused and tests showed that he had an abnormal heart rhythm.

He was initially restrained by means of an escort chain (a long chain with a handcuff at each end) but his behaviour was disruptive and so an additional set of handcuffs was applied. They were removed 24 hours later and the escort chain was removed on 8 November when he lost consciousness. He died at around 12.00 noon several days later.

The clinical reviewer concludes that he received appropriate medical care in prison. She highlights the nursing care he received whilst living in the healthcare inpatients unit as of a high standard. I make one recommendation about recording external hospital appointments. (The clinical reviewer makes a further four recommendations regarding recording practice that have been addressed separately to Wakefield.) In addition, I make a recommendation regarding healthcare input to the risk assessment process ahead of a prisoner's admission to hospital.

THE INVESTIGATION PROCESS

1. The investigation was opened on 18 November 2010, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.
2. The investigator visited Wakefield on 23 November. During the visit he met the Governor, the vice chair of the local Independent Monitoring Board (a body of local people who independently monitor and report on the prison), and the prison's family liaison officer. He also toured the establishment, including the healthcare centre and the wing where the man had lived. The investigator was provided with copies of his prison records.
3. On 17 February 2011, the investigator returned to Wakefield. During the course of the visit he interviewed four members of staff. At the conclusion of the visit, the investigator met the deputy governor to feed back the initial findings of the investigation. This was subsequently followed up in writing to the Governor.
4. A review of the man's clinical care in custody was undertaken by the clinical reviewer on behalf of the local Primary Care Trust. I am grateful to her for her assistance in this matter.
5. The Ombudsman's senior family liaison officer wrote to the man's daughter on 9 December 2010. She explained the purpose of the investigation and provided the opportunity for them to ask questions or raise any concerns they might have. No reply was received. I hope this report clarifies any issues that may remain unclear for the family and helps them better understand what happened in the time leading to his death.
6. My report was issued in draft to the National Offender Management Service (NOMS). Their response to my recommendations is included at the end of this report

HMP WAKEFIELD

7. HMP Wakefield is a high security prison for men in security categories A and B. (Category A prisoners are those whose escape would be highly dangerous to the public or national security. Category B prisoners are those who do not require maximum security but for whom escape needs to be made very difficult.) The capacity of the prison is 751 men, who are primarily serving sentences of over five years for sexual offences.
8. There are four main residential units, with each wing holding around 185 prisoners in single cells. The man lived in a ground floor cell on B wing. There is a lift on the wing to allow disabled prisoners to move to other landings and lifts elsewhere in the residential block for prisoners to use. Prisoners with limited mobility have stickers on the door of the cell so that staff are aware of this. (His cell had such a sticker on the door.)
9. Health services are commissioned by the local Primary Care Trust. There is a new primary care centre in the residential block, consisting of the prison doctor's consulting room and a treatment hatch (where prisoners' collect their medication). The main healthcare centre has consulting rooms for the dentist and optician, as well as a 19 bed inpatient unit.
10. Her Majesty's Chief Inspector of Prisons last inspected Wakefield in December 2008. The report noted that many older prisoners and those with disabilities complained about a lack of support and felt they were not consulted about their individual needs and care. It was also noted, however, that there was a committed member of staff who worked as disability liaison officer and coordinator for older prisoners. The report also noted that prisoners had to wait too long to see the prison doctor and too many outside hospital appointments were cancelled with little monitoring of the reasons.
11. The Independent Monitoring Board report for 2009-10 highlighted concerns regarding the suitability of accommodation and activities for older prisoners and those with disabilities. They reported that the healthcare team provided a comprehensive service, but noted their concern at a shortage of healthcare staff as a number were suspended following a security incident.
12. This is the seventh death of a prisoner at Wakefield since January 2009. All of the previous deaths were due to natural causes and many involved older prisoners who suffered from various chronic diseases. There were several recommendations made regarding the use of electronic medical records. Although the clinical reviewer makes recommendations regarding the use of electronic records, none are repeated from previous investigations.

KEY EVENTS

13. The man who is the subject of this report was born in March 1928, and had one brother and one sister. He left school at age 14 and worked in full time employment until reaching retirement age. He worked in a number of different jobs and was last employed as a salesman. He was married and had two sons and a daughter.
14. On 1 April 2003, he was convicted of a serious offence and sentenced to 12 years imprisonment. It was the first time he had been convicted of an offence and his first time in prison. He arrived at HMP Forest Bank the same day.
15. At the time of his reception into prison, the man had been diagnosed with high blood pressure and diabetes. He had also recently experienced symptoms of arthritis in his right knee and right hip, although a letter from his community doctor indicated that these symptoms had settled with resting. He was prescribed fenofibrate (to lower cholesterol), quinapril and co-amilozide (both for high blood pressure).
16. He moved to Wakefield on 23 June 2003. He settled in well at the prison and attended courses in the education block. He was described by staff who knew him as a quiet man who got on well with staff and other prisoners.
17. In September 2006, omeprazole was added to his medication. This is used to control acid indigestion and was prescribed as he had recently complained of loss of appetite and vomiting. Later in the year, he saw a mental health nurse as he had asked the prison doctor to prescribe diazepam (given to treat anxiety, commonly known by the brand name Valium). After an assessment, the nurse concluded that he showed no signs or symptoms of anxiety and did not therefore recommend that diazepam should be prescribed.
18. After complaining of pain in his calves, beginning in mid-2007, he was referred to a consultant vascular surgeon at hospital. An appointment was made for 11 December, at which he was diagnosed with intermittent claudication (cramping pain caused by a lack of oxygen to the muscles due to poor blood supply). The consultant asked the prison doctor to prescribe simvastatin (to lower his cholesterol) and arranged for him to return for a scan at a later date.
19. The scan was arranged for 23 January 2008, but was cancelled by the prison the day before for unspecified security reasons. It was rearranged for 6 February but, on the day, he refused to attend. The man said that he would only go if he was taken to reception in a wheelchair and if one was available for him at the hospital. He was told that he would only be given a wheelchair if healthcare instructed that it was necessary. He later changed his mind and said that he would go to the appointment, but he

20. At a review with a prison doctor on 12 March, it was noted that the man was unsteady on his feet at times. The doctor referred him to the wing's disability officer. She assessed him two days later and confirmed that he had problems with his mobility. The man said that he had pain in his legs when walking extended distances. The nurse concluded that he should be encouraged to maintain some mobility by walking around his wing, but could have the assistance of another prisoner when collecting his meals. Shortly afterwards, another prisoner was appointed to help him.
21. He went to hospital on 14 May for his scheduled scan. The result showed bilateral superficial femoral artery disease (the superficial femoral artery supplies blood to the calf and foot). He was prescribed cilostazol (medication to widen blood vessels) by the consultant. However, he stopped taking this medication after only a few days as he felt that it caused bruising.
22. In September, he had a review with the disability liaison officer. It was noted that he was settled and well on the wing. Two months later, he was referred to hospital as blood tests showed that he had a low level of sodium in his blood. He went to an outpatient appointment at hospital on 28 November, where it was determined that the low sodium level was due to him taking co-amiloride. This medication was subsequently stopped.
23. A prison nurse was called out to see the man during the night of 3 February 2009 as he said that he felt dizzy and his legs were weak. He saw a doctor the following morning and was diagnosed with a viral disease. A course of antibiotics was prescribed. Over the following week, the man said he found it increasingly difficult to walk. His ankles and lower legs were also slightly swollen. A prison doctor referred him for a chest x-ray to check whether his symptoms might be caused by heart failure.
24. The result of the chest x-ray was available in March and showed no features of heart failure. The man was prescribed frusemide for his swollen legs (frusemide is a diuretic that is used to treat excess fluid in the body). Later in the month, he saw the disability liaison officer for another review. It was noted that his mobility had declined in the past six months. However, the assessor thought this was partly self-imposed as he "... appears to enjoy ... having others run around after him". It was recommended that staff should encourage him to maintain his independence.
25. The man's parole eligibility date was 31 March (the earliest day he could be released, should the Parole Board consider his risk of re-offending to be sufficiently reduced). The Parole Board considered his release in early April but refused the application. The most significant factor in their refusal was that he denied his offences.

26. At a review with a prison doctor on 11 June, the man said that he could now only walk around 25 yards before the pain of his intermittent claudication set in. The dose of frusemide was reduced as he said he was not taking it regularly and the swelling to his legs was now noted to be minimal.
27. The next disability review went ahead in September. He tried to remain independent where he could. An entry in his wing history sheet also commented that he was fairly independent and only needed help to collect meals and mop the floor of his cell.
28. On 23 October, the man saw Prison Doctor A and said he had experienced speech loss twice in the last four days. Each episode lasted from 12 to 24 hours. Blood tests were taken, which showed nothing abnormal. He was referred to a visiting consultant who runs a weekly respiratory clinic at the prison.
29. The man saw the consultant six days later. The consultant thought that he might have chronic obstructive pulmonary disease (COPD is used to describe airflow obstruction to the lungs due to chronic bronchitis, emphysema or both) and asked for a spirometry (a test of how well the lungs are working) to be arranged to confirm. There is no indication that this test went ahead.
30. The Parole Board met again on 4 February 2010, to discuss his possible release. As previously, parole was refused on the same grounds that he denied his offences.
31. A week later, the man saw Prison Doctor B after complaining of a loss of vision when he woke and feeling weak in his legs. The doctor noted that he was alert and oriented, but seemed slightly confused and queried whether he might have had a transient ischaemic attack (TIA, when the patient experiences symptoms similar to a stroke that go within 24 hours) and asked for him to be monitored for the remainder of the day.
32. At his next disability review, in March, it was noted the man now used a wheelchair to cover longer distances around the prison. He was described as "upbeat" and the conclusion of the review was he should continue to be encouraged to be independent. A disabled care plan and personal evacuation plan were written in May, in which it was noted that his mobility was poor and he used a wheelchair if he left his wing. Another prisoner still collected his meals for him, and friends on the wing helped him to clean his cell.
33. He went to the visiting consultant's clinic at the prison for review on 17 June. He told him that he had no breathing problems or chest pain, but became breathless when participating in strenuous activity. The consultant noted that he had not had the spirometry test which he had requested in October 2009. He requested that this be booked and that

34. A Person Escort Record (PER, the log of events recorded by staff when a prisoner is away from the establishment) indicates that he went to hospital on 9 July for a CT scan (a type of scan that produces a more detailed image than an x-ray). There is no indication in his medical record that he went to this appointment or of the outcome of the scan.
35. A nurse was called to see the man in the early hours of 1 September when he fell over whilst trying to use the toilet. The nurse noted that he had no visible injuries, although he said he felt he had little strength and was unable to support himself. Later that day, Prison Doctor A saw the man in his cell. He observed that he had some mild left sided weakness and had difficulty coordinating. He decided that he should be admitted to the healthcare centre inpatients unit for observation and assessment.
36. The following day, a care plan was created to detail how his care should be managed whilst he lived on the inpatients unit. The care plan focused on how staff might encourage him to stay mobile and help with his personal hygiene. On 4 September, he moved to a cell near to the nurses' station so that he could be observed more closely.
37. On 6 September, a physiotherapist saw the man for an assessment. The conclusion was that he required a Zimmer frame to help him walk around the unit. This was provided and, over the following two weeks, he was observed to be moving well with his frame. Having seemed confused in his first days on the unit, he became more oriented in his second week. By 22 September, he was judged well enough to return to B wing. One of the doctors decided that it would be beneficial for him to walk independently when he returned to the wing and so he did not take the frame with him.
38. The man appeared to settle well back on B wing. On discharge from healthcare, his medication was listed as omeprazole, quinapril, frusemide and simvastatin. When interviewed on 6 October ahead of a forthcoming parole review, he said that he no longer wished to be considered for parole. He later confirmed this in writing, although gave no reason for his decision. On 17 October, he submitted an application in which he said that he did now wish to be considered for parole.
39. On the morning of 4 November, Nurse A saw the man in his cell. This followed a request by Officer A, who was concerned that he appeared confused when he unlocked his cell that morning. The nurse described him as "unable to understand simple verbal commands". She requested that an electrocardiogram (ECG, a test to measure the electrical activity of the heart) was carried out. The test was completed shortly afterwards by Nurse B. The ECG showed atrial fibrillation (abnormal heart rhythm) and

40. Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. The risk assessment determined that he was to be accompanied by two officers and cuffed to one of them by means of an escort chain (a long chain with a handcuff at each end).
41. Officer B was one of the escorting officers on the morning that he went to hospital. He told the investigator that the man was extremely confused and appeared to understand little of what was said to him. On several occasions during the morning and afternoon, he tried to remove his pyjama trousers. The officer and his colleague, Officer C, asked him not to do this but, due to his confusion, were unable to communicate with him effectively. He also tried to get out of bed a number of times. Officer B recalled that he was unsteady on his feet and he was concerned that he would fall and hurt himself.
42. On account of the man's attempts to remove his trousers and thus expose himself, Officer B applied a standard set of handcuffs at 4.45pm to complement the escort chain (known as 'double cuffs'). He explained at interview that he refrained from adding the extra restraints for as long as possible, but felt he had no alternative as the man was on an open hospital ward and his behaviour was challenging. Officer C, who was the other officer on the bedwatch, contacted the prison afterwards to tell them about this change.
43. When the standard handcuffs were in place, the man began to pull at them. Officer B thought that this was because he wanted them to be removed. By pulling at the handcuffs, the man caused his wrists to bruise. On account of the bruising, SO A removed the standard handcuffs at around 7.20pm, shortly after he took over the bedwatch with a colleague. This meant that he was again only restrained by the escort chain.
44. Over the following four hours, the man was described as continuously trying to pull the escort chain off his hand. He also tried to get out of bed several times. As a result, the SO reapplied double cuffs at 11.25pm. Throughout the night, the man continued to try to pull his hands out of the handcuffs and it is recorded that he tried to kick the officers on two occasions.
45. On the morning of 5 November, Nurse B telephoned the hospital to ask for an update. She was told that the man was "agitated and confused" with possible "delirium secondary to chest infection". The same morning, a new risk assessment was authorised by the Head of Security at Wakefield. This is a standard requirement 24 hours after a prisoner is admitted to hospital. The risk assessment contains a section for

46. At around 12.30pm, a manager in the security group at Wakefield visited the man as part of her responsibilities as duty governor. During her visit, one of the hospital doctors spoke to her and asked for the handcuffs to be removed on account of the man's health and the bruising to his arms and wrists. She spoke to the bedwatch staff and noted that he was "extremely confused". She decided that the handcuffs should be removed and that only the escort chain should be used. The risk assessment was updated accordingly.
47. A family liaison officer was appointed on 6 November to contact the man's family and tell them that he was in hospital. He initially tried to telephone the man's wife on several occasions that afternoon and evening, but was unsuccessful. He was able to speak to her the following morning and, that afternoon, she and her daughter visited him in hospital.
48. On the morning of 8 November, SO B, who was in charge of the bedwatch, contacted the duty governor and asked permission to remove the escort chain. The man was now unconscious and his wrist was still bruised. The duty governor gave permission to remove the escort chain. It was not reapplied during the remainder of his life.
49. He remained unconscious over the following days. There was some discussion on 12 November between prison healthcare and the hospital with regard to discharging him back to Wakefield. It was agreed that it was better for him to remain in hospital for the time being. This was discussed again three days later, with the same outcome.
50. At around 12.00 noon a few days later, the bedwatch staff observed that he had stopped breathing and asked for the assistance of hospital staff. Shortly afterwards, a doctor pronounced that he had died. The cause of death was later found to be bronchial pneumonia.
51. That afternoon, the family liaison officer and a prison chaplain visited the man's wife and daughter to break the news of his death. His funeral took place on 25 November, and was arranged by the family liaison officer and conducted by the prison chaplain. The prison paid for the costs of the funeral. A memorial service was also held at Wakefield, which was attended by staff and prisoners who knew him.

ISSUES

Clinical care

52. A clinical review was conducted on behalf of the local Primary Care Trust. The clinical reviewer concludes that the man “appeared to have adequate healthcare whilst in prison”. She notes that his personal care needs were addressed both on B wing and during his brief stay in the healthcare inpatients unit. Indeed, she considers that he received a “high level of nursing care” whilst an inpatient and was treated respectfully at all times. She also concludes that his illness and subsequent hospital admission on 4 November 2010 were handled in a timely manner.
53. When the man saw the visiting consultant at his respiratory clinic in October 2009, a spirometry was requested to check for COPD. This test does not appear to have gone ahead. When he next saw the man, in June 2010, the consultant again asked for a spirometry to take place. As previously, there is no indication that this test went ahead.
54. The healthcare manager at Wakefield told the investigator that there was a period without a trained respiratory nurse to carry out spirometry and similar tests at the prison. Nurse B has subsequently been trained as a respiratory nurse and has been able to work through the backlog of tests. I trust that the waiting list will be monitored in future to ensure that all patients who are recommended for such tests at the respiratory clinic can undertake them in a timely manner.
55. A PER form completed on 9 July 2010 indicates that the man went to hospital on this date for a CT scan. There is no indication in his medical record that this appointment took place or of what the outcome might have been. Healthcare professionals at the prison would therefore have to treat him without knowing the outcome of this potentially important scan.

The healthcare manager should review the process of recording prisoner outpatient appointments. This should include a record of when a prisoner attends outside hospital, who they see and the outcome.

56. The clinical reviewer also highlights concerns regarding record keeping at Wakefield. She makes the following recommendations to the healthcare manager:
 - To ensure that the role of each member of staff is clearly identified when entering consultations.
 - To regularly audit the quality of the consultations to ensure there is no ambiguity and the entries are understandable.

- To examine the access to clinical systems for staff to reduce the incidence of entries being made after the event and by other practitioners.
- To look at the feasibility of having just one system of clinical notes across consultation sites to remove the risk of missing information in handwritten notes that is not seen in SystmOne notes thus increasing the risk of health issues not being adequately addressed.

57. These recommendations have been put to prison healthcare separately by the clinical reviewer and have been accepted.

Use of restraints in hospital

58. A risk assessment was carried out on 4 November 2010, when an ambulance was called for the man. The purpose of this initial assessment is to determine the security arrangements necessary in the ambulance and on escort in hospital. A second risk assessment has to be completed within 24 hours of admission to hospital.
59. The risk assessment has a section to be completed by healthcare staff. This contains questions relating to the nature of the appointment and whether there are medical objections to the use of restraints. It also asks whether the prisoner suffers from impaired mobility. The healthcare section of the risk assessment on 4 November was completed by the healthcare manager. He noted that there were no medical objections to the use of restraints. He did not complete an answer to the question regarding impaired mobility.
60. At interview, he said that the man was not a prisoner who he knew. He added that this did not matter in these circumstances because, on an emergency admission to Accident and Emergency, it would usually be the case that the prisoner would be restrained by an escort chain (as was the case for the man).
61. I appreciate that there are significant time constraints involved in completing the escort risk assessment whilst waiting for an ambulance. Nevertheless, my view is that there is little value in completing the health section of the risk assessment if it is undertaken by a member of staff who does not know the prisoner or their individual circumstances. Whilst it might not have made a difference to the security arrangements put in place, a more informed decision could have been made had the man's impaired mobility been reported.

The Governor and healthcare manager should ensure that, where possible, the medical section of the escort risk assessment is completed by a member of healthcare staff who is aware of the individual circumstances of the prisoner involved.

62. The risk assessment has to be authorised by the Governor, deputy governor or Head of Operations (although arrangements are in place for alternative authorisation should none of these be available). The assessment on 4 November was authorised by the deputy governor. He approved the use of an escort chain only. Given that the man was considered a high risk to the public (as he had not undertaken any offending behaviour work and denied his offences), I consider this level of caution to be understandable at this time.
63. In hospital, the man's behaviour was sometimes bizarre and included trying to remove his pyjama trousers (with the risk that he would expose himself), kicking the staff and pulling the handcuffs. In these circumstances, particularly given that he was located on an open ward, it is understandable that staff would use caution and apply double cuffs when they did. (This action was supported by the risk assessment completed on 5 November.)
64. However, it appears that his behaviour was caused by delirium and confusion brought on by his ill health rather than a concerted attempt to cause trouble. As such, it is questionable whether it was correct to restrain him further. This is particularly the case given the bruising that restraints caused him. (I note that the double cuffs were reduced to an escort chain by a manager in the security group on account of his bruising and general ill health.)
65. My conclusion is that, given his age, mobility, ill health and, particularly, his mental state, the use of double cuffs was not appropriate. However, these circumstances demonstrate the difficult decisions that prison staff can be faced with when balancing decency and security considerations. I therefore do not intend to criticise those who made the decision to apply double cuffs as I can quite understand why they might have reached this judgement. I also appreciate Officer B's comments at interview that he refrained from applying double cuffs for as long as he thought he could.
66. Prison staff might have made a different judgement about the level of restraints had they had more understanding of the man's condition and what was causing his behaviour. The advice of hospital staff could have been sought to determine if there was any other way of managing his behaviour, particularly with regard to how a man who was not a prisoner would have been managed in these circumstances.
67. If the hospital had a greater understanding of the circumstances when treating Wakefield prisoners, it is possible that alternatives could have been arranged. For example, placing him in a side ward would have considerably reduced the risk of re-offending.
68. I make no recommendation on this occasion but urge the Governor and healthcare manager to consider whether there is a need to train staff who may undertake escorts about the options available to them in such circumstances.

CONCLUSION

69. Despite his age and steadily deteriorating mobility, the man got on well at Wakefield. He required some assistance with collecting meals and cleaning his cell but, other than this, maintained his independence as much as he could. The clinical reviewer concludes that he received appropriate healthcare at Wakefield, particularly during his three week stay on the inpatients unit. I am also impressed by what I have learnt about the work of the prison's disability officer. She reviewed him regularly, ensuring that his independence was maintained but appropriate support and equipment was provided.
70. Following a deterioration in his health on 4 November 2010, the man was admitted to hospital. His behaviour in hospital was described as bizarre, seemingly brought on by delirium and confusion due to his ill health. Given the circumstances, prison staff faced a difficult choice regarding the use of restraints. Although I conclude that the use of double cuffs, albeit on a short term basis, was not necessary, I quite understand why this decision was reached. I do not make a recommendation but I encourage the Governor to establish a protocol with the local hospital to avoid this situation being repeated when another prisoner is admitted.

RECOMMENDATIONS

1. The healthcare manager should review the process of recording prisoner outpatient appointments. This should include a record of when a prisoner attends outside hospital, who they see and the outcome.

Accepted – This process will be reviewed as part of the ongoing general efforts for continuous improvement in record keeping.

2. The Governor and healthcare manager should ensure that, where possible, the medical section of the escort risk assessment is completed by a member of healthcare staff who is aware of the individual circumstances of the prisoner involved.

Accepted – We will ensure that the process completing the medical sections of the escort risk assessment includes reference to the prisoner's individual circumstances.